PART B: Improvement Targets and Initiatives 2014-15

Strathroy Middlesex General Hospital

AIM		MEASURE				CHANGE			
Quality dimension	Objective	Measure/Indicator	Current performance	Target for 2014/15	Target justification	Planned improvement initiatives (Change Ideas)	Methods and process measures	Goal for change ideas (2014/15)	Comments
Safety	Reduce clostridium difficile associated diseases (CDI)	**CDI rate per 1,000 patient days**: Number of patients newly diagnosed with hospital-acquired CDI, divided by the number of patient days in that month, multiplied by 1,000 - Average for Jan-Dec. 2013, consistent with publicly reportable patient safety data	0.44 rate (7 cases)	Meet or exceed provincial average 0.29	Maintain or improve upon current rate to meet or exceed the provincial average	1) Antibiotic Stewardship(ABS) ●increase emphasis on antibiotic stewardship through the HUGO (Healthcare UnderGoing Optimization), electronic Provider Order Entry (CPOE) initiative ●order sets will define the appropriate antibiotic for the admitting diagnosis so that there is more judicial and targeted use of antibiotics ●the pharmacist will verify orders as a secondary safety measure ● the HUGO order set for the treatment of CDI will standardize treatment for all admitted patients and help reduce relapses ● in the fall of 2013 the pharmacist started receiving a twice weekly report of antibiotic prescriptions, used for tracking and reporting antibiotic utilization to P&T	●HUGO will be fully implemented in Feb 2014 ● Designated metrics and a report for appropriate antibiotic prescribing will be initiated.	●Develop a reporting tool that monitors evidence based prescribing practices through implementation of HUGO order sets	●With implementation of HUGO, clinical interventions documented by the pharmacist with respect to antibiotic stewardship will be captured in the Electronic Patient Record (EPR) ●Post HUGO implementation, a review of available reports will be completed and a measurable metric for reporting of ABS established . ●The CDI cases continue to be reviewed on a case by case basis with the ICP (Infection Control Practitioner) and Pharmacist ● Quarterly reports to the Infection Control Committee and Pharmacy and Therapeutic Committee (P&T)
						2) Cleaning Practices ● in 2013 switched CDI cleaning from hydrogen peroxide to a bleach cleaner for daily and terminal cleaning and commenced room audits using an Adenosine Triphosphate (ATP) measuring system ● Initiated a standing report of audit results to Infection Control Committee	●ATP measurements collected and correlated by housekeeping department and will now be an standing agenda item for quarterly month reports to the infection control committee	●100% compliance with cleaning protocols for CDI terminal clean as reflected in meeting the ATP parameters for clean	● housekeeping transitioned from qualitative measuring with fluorescent markers to qualitative measurement with ATP ● Every terminal clean room is audited and recleaned and audited until the compliance parameters are met ● the cleaning protocol is performed as outlined in the Provincial Infections Diseases Advisory Committee (PIDAC) and verified through a cleaning checklist
						3)Hand Hygiene ●Hand hygiene continues to be a corporate priority with expansion of initiative to a more comprehensive practice though departmental auditing rather than centrally	●Train department auditors so that the auditing can expand to incorporate other shifts and help with peer encouragement for good practices ●Continue to utilize the Mariner -online program to track and report compliance numbers	●maintain the 90% hand hygiene compliance goal previously established	●will expand the number of auditors to provide a more robust denominator and generate a new perspective on promoting hand hygiene within the facility

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	Medication Reconciliation at admission	**Medication reconciliation at admission.** The total number of patients with medication reconciled as a proportion of the total number of patients admitted to the hospital. Q3 2013/14	96%	90%	Meet or continue to exceed performance target.	The HUGO CPOE implementation will improve the overall performance. With electronic physician order entry, medication reconciliation on admission will be captured.Quarterly reporting through the National Safer Health Care Now network, monitoring and sharing of performance internally.	Ongoing monitoring and review of statistical data available through Electronic Patient Record (EPR). Track each occurrence of a medication administration related to the medication reconciliation. Review for process improvement and elimination of errors. Quarterly reporting to Pharmacy and Therapeutics Committee.	Greater than or equal to 90%	With implementation of HUGO CPOE, medication reconciliation is expected to meet or exceed the target. Medication Reconciliation is also recognized as an Accreditation Required Organization Practice (ROPS) and SMGH met required elements in Accreditation survey Fall 2013. Also capture and report - Medication Reconciliation on patient transfers.
Effectiveness	Improve organizational financial health	**Total Margin (consolidated):** Percent by which total corporate (consolidated) revenues exceed or fall short of total corporate (consolidated) expense, excluding the impact of facility amortization, in a given year. Q3 2013/14 OHRS	0.36	Greater than or equal to 0.	Zero or greater indicates good total margin.	1) Sustaining Total Margin Currently achieving performance goal and will continue to monitor through Board Finance Committee. Sustaining Total Margin at zero or better. Ongoing analysis and education surrounding Health System Funding Reform / Quality Based Procedures and Health Based Allocation Model. A new Financial Planning Analyst role is actively involved in Ministry funding analysis as well as planning and benchmarking analysis. The hospital is engaged in many regional initiatives to enhance patient care which are tied to performance. They include the SW LHIN Regional Integration Decision Support team; the SW LHIN Local Partnership Initiative to identify funding issues and challenges while providing education; the SW LHIN Integrated Health Plan looking at clinical services planning; and Regional Orthopaedic Services. The hospital continues to monitor changes to the Not-For-Profit Corporations Act and the potential impact on governance and changes to Cost Per Weighted Case.	Monthly financial tracking and reporting. Enrollment in HBAM and QBP HSFR education sessions and review of resources provided. The hospital has initiated 3 year operational and capital budgets. LEAN project challenges will continue throughout the organization to reduce costs.	Monthly completion of finance account by manager of finance, reported to CFO within 2 weeks of month end. Quarterly report to Finance Committee of the Board and publicly quarterly through corporate dashboard.	This is a priority item because it is tied to Health System Funding Reform funding and changing HBAM and Quality Based Procedure Funding. LEAN initiatives related to improved patient care , education, access, but also costing continue. The priority is in managing limited funding with cost pressures while at the same time sustaining and improving the orthopedic program. The assumptions we make are at risk without timely input from the Ministry of Health and Long Term Care.

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						2) Quality Based Procedure (QBP) Funding Transformation Steering Team . This leadership team is under development with the intent to support and act as the steward of the implementations of QBP's across the organization. The Funding Transformation Team will focus primarily on the QBP's in an effort to leverage and optimize quality and efficiency within the new funding model. The team will review provincial handbooks, admission and readmission volumes, current and recommended practice variations, staff and patient education, electronic CPOE and pathway development , costs .	●Each QBP will have associated provincial and internal metrics ●Regular monitoring of patient outcomes and cost will be reported as determined by the team	Goals include: -Development, pilot and evaluate a process working through QBP. Apply successful process to remaining QBP -Optimize patient outcomes, creating efficiency and cost savings -Optimize QBP volumes and funding dollars. Educate all physicians and staff of each QBP and their role in delivering it	
Access	Reduce wait times in the ED	**ER Wait times:** 90th Percentile ER length of stay for Admitted patients. Q4 FY 2012/13 -Q3 2013/14	13.3	9	NEW Stretch Target ED Admitted LOS Triage to admit 9 hours (Triage to decision to admit is 4 hours; decision to inpatient bed is 5 hours) established by SWLHIN ED Knowledge Transfer Group Smart Goals.	Currently participating in Knowledge Transfer Lean SWLHIN initiative to look at LOS of admitted patients and develop strategies to decrease the time to inpatient beds/standardize care plans and look at predictable discharge planning. New targets identified to be met by end of year 2014. Goal is to free up inpatient beds so when the decision to admit is completed, the patient will be transferred to the unit with a defined amount of time.	●Implementation of white boards in the inpatient areas to assist with predictable discharge expectations, communication pathways ●Enhance more patient centered care focus of staff, managers and Clinical Leader ● Utilize the DART information to help understand/predict heavy discharge and admission days to help with bed management/ decrease ALC patient days/Implement Home ●Better utilize our CCAC partners/continue with daily huddles on Inpatient Areas	Target of 9 hours by Dec 2014	Great focus by the entire organization to decrease wait times in the ED. Collaboration between all managers and frontline staff to manage these goals and expectations/HUGO will assist as care plans have been generated to assist with standardization of care in the ED/focus is on the 90th percentile as the ED is a volume dependant area and is unpredictable/Home First will be an asset to our plan as it will get patients home vs. waiting in acute hospital beds for LTC beds for lengthy time frames.

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Patient- Centered	Patient Satisfaction	**From NRC Picker:** "Overall, how would you rate the care and services you received at the hospital?" Q3 2012/13- Q2 2013/14	92.90%	93%	Meet or exceed provincial benchmark.	1) ED Knowledge Transfer initiative improvements will improve patient satisfaction by reducing length of wait and improve patient throughput. Improvements plans include decrease LOS for admitted patients, standardized care plans, faster time to admit decision by MD , and communications of current demands on the department when wait times are lengthy. 2) Inpatient and Surgical Day Care (SDC) review of satisfaction results and areas of high and low satisfaction by category. 3) ED Follow-up phone calls made to patients who left without being seen (LWBS) 4) Sustain expectation of 2 business day response to patient and family complaints, currently greater than 90%. Responding to patient complaints early helps to demonstrate accountability	1) The Daily Activity Reporting Tool (DART) is displayed to the physicians and staff to inform up to date wait time indicator performance reflect on how/why and determine if there is any improvements to be made 2) Monitor the reports for the number of patients LWBS remain stays low or nil/respond to all complaints re:wait times and if its a flow issue then get all stakeholders involved to improve i.e.. DI/Lab/Inpatient units. 3) Satisfaction results, compliments and complaints shared at individual and staff meeting level and at Board Quality Committee.	Daily DART monitoring. Same day reciept and review complaints , two business day response to complaint. Meet or exceed provincial benchmark 93% satisfaction.	Communication seems to be a common complaint amongst patients when interviewed over the phone. Clear and regular communication of wait times and reasons for the wait, ensure patients feel they are valued and not forgotten. The initial contact with triage nurse can set the tone for the visit-so coaching to all triage trained nurses to be self aware of all communication styles, personal or physical.
Integrated	Reduce 30 Day Readmission Rates to Any Facility	**30-Day Readmission Rate to Any Facility-** The number of patients with select case mix groups(CMGs) readmitted to any facility for non-elective inpatient care within 30 days of discharge, compared to the number of expected non-elective readmissions using data from all Ontario acute hospitals. Q2 FY 2012/13-Q1 FY 2013/14. DAD/CHIHI	15.35	13.8	16.35 Provincial readmission rate . Target established based on 10% improvement	Daily Huddles with focus on individual discharge planning. Health providers identify patient areas of risk in consideration of transition from hospital, plan and facilitate accordingly to provide support or reassessment of key areas of risk. Perform medication reconciliation on admission and discharge. Provide each patient with their individual discharge plan including options for assistance, self monitoring and specific medications and changes.	Review of readmission rates by diagnosis.Review and compare to associated QBP clinical handbooks and best practices. Completion of HARP readmission risk assessment tool. Medication reconciliation completion.Individualized care plans including assessment of current education tools and patient understanding, and timely plans for followup.	To gain greater understanding of readmission rates and populations at risk. Maintain or improve upon current readmission rates given data under review is not current.	Tracking and monitoring number and timing of readmissions. Tracking completion of medication reconciliation on admission and discharge. Assessing and understanding the areas of priority improvement.

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Integrated	Reduce unnecessary time spent in acute care	**Percentage ALC days:** Total number of inpatient days designated as ALC, divided by the total number of inpatient days. Q3 2012/13-Q2 2013/14, DAD, CIHI	16.6	14.9	Reduce ALC days by 10% with focus on Home First program improvements.	1) HOME FIRST SWLHIN CCAC Early stages of HOME FIRST implementation by team of internal staff members, CCAC representatives and facilitators. Formal program communications underway to promote understanding of intent of the program to promote home primary discharge, completion of Long Term Care (LTC) applications in community if needed, CCAC capacity to care for high-needs patients in community, engage and inform community support and primary care services.	•Communications to internal and external stakeholders •Training and implementation of assessment tools to identify patients at risk •Foster a culture of from home as the primary discharge destination to all care providers early from arrival ED, physicians, community •Review of existing ALC metrics regarding number of ALC patients , discharge disposition, and discharges home versus LTC monthly; ED Admitted LOS, ALC LOS patient days quarterly • Continued daily huddles to identify and reinforce patient plans.	• Timely assessment and identification of patient at risk for discharge home within 24 hours of admission • Reduce ALC hospital days to target or below by reducing LTC wait associated LOS •Increase volume of patient discharges with Home as discharge disposition for at risk patients	Early in the stages of Home First Implementation, expecting gradual change in results with achievement of LOS target in Q3 2014-15
						2) ALC CCC, Rehab Access Working closely with CCAC and SW LHIN regional hospitals. Promote the expected access to regional complex continuing care and rehabilitation beds following the recent review and realignment of the same resources throughout SW LHIN.	•Communicate the availability of hospitals with units providing support to these patient populations once they have completed their enhancements internally. •Provide communications and education internally regarding patient flow, assessment and transfer planning once provided to referring facilities Fall 2014-15.	Goal to improve the access of patients requiring complex continuing care or rehabilitation to care in the right place, reduce ALC length of stay in acute care beds, improve patient outcomes, and improve accessibility to acute care beds for acute patients.	Acute hospitals without CCC, rehabilitation beds will have access for external patient transfers by Q3 2014-15
						3) ALC Reduced Length of Stay Continue to identify ALC patients in timely and appropriate manner. Incorporate expanding options into consideration Home First, CCC, Rehab, LTC during daily huddles and patient conferences.	•ALC order entry moving to Electronic Care Provider Order Entry , enhancing timeliness of communication of ALC orders and associated planning. • Increased number of LTC beds and facilities with spring 2014 opening. • Review of ED admission practices of patients with high conservable days quarterly.	Goal to improved LOS by hospital wide focus to discharge patients home in safely and timely manner.	